General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Landsdowne Pharmacy, 5-6 Lansdown Road, Yaxley, PETERBOROUGH, Cambridgeshire, PE7 3JL

Pharmacy reference: 1029323

Type of pharmacy: Community

Date of inspection: 18/02/2020

Pharmacy context

This community pharmacy is opposite a medical centre in a largely residential area. Its main service is dispensing NHS prescriptions, a proportion of which are delivered to people's homes. It also supplies some medicines in multi-compartment compliance packs to people living at home. Other services provided include Medicines Use Reviews (MURs) and a small number of New Medicine Service (NMS) checks. It has a small number of people who receive instalment supplies for substance misuse treatment. And it has received some referrals through the Community Pharmacy Consultation Service, mainly at weekends.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

Follow this link to find out what the inspections possible outcomes mean

Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards not all met	1.1	Standard not met	The pharmacy doesn’t manage risks effectively. It doesn't have up-to-date procedures which tell its staff how to work safely.
		1.6	Standard not met	The pharmacy doesn’t make all the records it needs to by law within the required timescales. And it doesn’t have adequate processes in place to investigate any discrepancies in its records promptly.
		1.7	Standard not met	The pharmacy doesn't have robust systems for disposing of all confidential waste effectively. And the way that it stores some prescriptions increases the chances that people’s information could be disclosed in error.
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy cannot show that all medicines which require refrigeration are stored at the correct temperatures.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy doesn't manage all the risks associated with its services effectively and so it is not meeting all the standards for registered pharmacies. It doesn't have up-to-date procedures which tell staff how to work safely. It doesn't make all the records it needs to by law within the required timescales. And it doesn't have adequate processes in place to investigate any discrepancies in its records promptly. The way that some prescriptions are stored increase the chances that people's information could be disclosed in error. And it doesn't make sure that all confidential waste is disposed of correctly. The pharmacy team members try to learn from their mistakes and make improvements in the dispensing process. But they don't always record why mistakes have happened. So, they may miss opportunities to spot any patterns or trends and make further improvements. And there is no information for people about the pharmacy's complaints process. This may mean that people don't know how they can raise a complaint or provide other feedback about the service they receive.

Inspector's evidence

The pharmacy had changed ownership mid-2018 and a new superintendent (SI) had been appointed at that time. The superintendent provided most of the responsible pharmacist (RP) cover at the pharmacy and was on duty during the inspection. He explained that he had obtained some standard operating procedure (SOP) templates and intended reviewing and introducing these so they accurately reflected how this pharmacy operated. However, he had not done so yet. The only SOPs that had been read by staff still related to the previous ownership and had last been reviewed in 2016. The current SI had not reviewed these SOPs since taking over. And some of the staff had not read SOPs that were relevant to their roles.

Staff were aware of when they needed to refer queries to the RP and were seen doing so during the inspection. They understood what they could and couldn't do if there was no RP at the pharmacy. And they could explain the restrictions on sales of some products including medicines containing codeine. When asked, one of the medicine counter assistants said she would not sell any foot treatments to a person who had diabetes so as not to cause any harm. Staff could be identified by members of the public as they wore uniforms and had name badges. The medicine counter assistants knew they could not carry out any dispensing tasks.

There was some evidence of the pharmacy responding to dispensing incidents to reduce the possibility of similar events happening again. To prevent selection errors between pregabalin and gabapentin, notices had been placed where these items were stored in the dispensary, reminding dispensers to double-check they had chosen the right product. Other similar notices had been placed near sildenafil and sertraline. Some mistakes which were spotted and changed during the dispensing process, referred to as near misses, had been recorded. The SI said that he briefed the team about common mistakes and would tell the dispenser about any mistakes he found. The SI recorded near misses and there was no information in the records about why a mistake had happened or what the learning points or improvements were. Dispensing errors which had left the pharmacy were recorded and reported to the National Reporting and Learning System by the SI.

Staff were able to explain how a complaint should be handled and would refer to the pharmacist on

duty when needed. There was no information about the pharmacy's complaints process displayed in the pharmacy. The pharmacy undertook an annual survey to gather feedback from people who used its services. The results of the survey completed in 2019 were not available in the pharmacy or on the NHS website.

The pharmacy had professional indemnity and public liability insurance. There was a notice displayed for the public showing who the RP on duty was though this was obscured from view at the start of the inspection and had to be repositioned. The record about who the RP had been was available and was complete. Private prescriptions were recorded in a book. The last entry had been made on 20 January 2020 and there were several prescriptions supplied since that date which had not yet been recorded. The entries viewed did not include the date of the prescription or the prescriber's name. Records about CDs were generally kept up to date. Running balances were recorded and checked; the last checks were made in September 2019. The recorded stock of an item chosen at random agreed with physical stock. However, a discrepancy in the balance of one item detected two weeks before the inspection had not yet been investigated. CDs returned by people for destruction were recorded as soon as they were received. There was a signed audit trail kept of their destruction. The pharmacy had recently obtained new denaturing kits to destroy those outstanding.

When asked, staff could describe the need to keep people's information private. The SI had some understanding of the General Data Protection Regulation but had yet to complete any training about it. The dispenser was using their own NHS Smartcard to access electronic prescriptions and would not disclose her password to anyone else. Computer screens containing patient information could not be seen by the public. Confidential waste was said to be separated from normal waste and taken off-site for burning. Or the SI ripped up any confidential waste before disposing of it with other waste. However, when checked, it was still possible to see patient details on ripped-up paper disposed of with other waste. There were several bags containing dispensed prescriptions on hangers in the consultation room; some details about the medicines and people's names were visible. The SI said he would review how these were stored in future to reduce risks to people's privacy.

The SI had completed level 2 safeguarding training. When asked, the delivery driver could explain what he would do if he had concerns about a person he took medicines to. He had sometimes checked people's medicines and realised they were getting confused with them. He had reported this back to the pharmacy so the person could get the support they needed.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has just about enough staff to cope with its workload though it has limited options to manage holidays. Team members use quieter times to complete tasks which need particular care. They work closely together and communicate well with each other. And they have the right qualifications for the roles they undertake. But the pharmacy doesn't have a structured approach to ongoing learning and development. So, it may be harder for team members to keep their knowledge and skills up to date.

Inspector's evidence

There was one pharmacist on duty during the inspection (the SI), two medicine counter assistants, and a dispensing assistant. In addition to this, the pharmacy team included two dispensers who were on annual leave and a delivery driver. The SI said that staffing levels were tighter than usual because of having two people off at the same time which was unusual. It was busy throughout the visit, but the team members were just about coping with the workload. The two medicine counter assistants were serving customers promptly and they appeared to have a good rapport with their customers. Some of the dispensing and checking activity was left until later in the day when it was quieter and there was less walk-in trade. The team members were seen discussing queries with each other throughout the visit and referring issues to the SI where needed.

There were training certificates for all the support staff, showing the pharmacy qualifications they had achieved. The staff said they didn't currently have formal training plans or reviews with the SI. They said they used trade magazines to help keep their skills and knowledge up to date. Two members of the team had attended a training event about healthy living so they could provide advice to people about this.

There were informal team discussions from time to time about issues or incidents that had occurred and to provide updates to the team. Members of staff said they felt able to raise any concerns with the SI. And they could make suggestions about how to improve the pharmacy but felt these were not always listened to. The SI did not set targets for staff and was able to exercise his professional judgement to act in the best interests of people.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are adequate for the services it provides. But the pharmacy could do more to make sure all dispensed medicines are stored securely. And fire exits must always be accessible when the pharmacy is open.

Inspector's evidence

The entrance to the pharmacy was at street level and the door was wide enough to accommodate prams or wheelchairs. The shop floor area was reasonably clear of clutter and there were no trip hazards. Medicines stock was kept off the floor. Access to the dispensary was restricted. Members of staff had good visibility of the medicine counter and pharmacy-only medicines were stored out of reach of the public. The pharmacy could be secured against unauthorised access. There was a WC and separate handwashing facilities available for staff. The sink in the dispensary used for reconstituting medicines was clean. Soap and hot and cold running water were available.

The dispensary was a galley style and was small for the volume of dispensing undertaken. There was very limited storage space for stock and dispensed items. The premises were fitted out to a basic standard but were generally clean, bright and well-maintained. The room temperature was appropriate for storing medicines and could be controlled. Lighting was adequate for safe dispensing. There was a small consultation room, accessed from the shop floor. The room was somewhat cluttered in appearance. There was a large window in the door which could reduce privacy for people using the room. The SI said he would consider screening the window for some services. The size of the room would make it difficult to have people accompanied by a chaperone.

Most dispensed items waiting collection were stored behind the medicines counter and were screened so that people's information could not be easily seen by members of the public. The pharmacy had introduced improvements in the way that the prescription retrieval system was set up to make best use of the available space and had added more storage space above the dispensing workbench to store compliance packs in a more orderly way.

There was a rear door at the side of the dispensary which was marked as a fire exit. At the time of the inspection, this door was blocked with waste cardboard which was due to be collected for disposal later the same day. The SI said he would review the positioning of this in future so as not to block the fire exit.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy doesn't always manage its medicines well. It can't show that its medicines are always kept at the right temperatures. It checks the expiry dates of its stock, but it doesn't keep a record of these checks. This could increase the chance of some stock being missed. But it does get its medicines from reputable suppliers. And it takes the right action to remove stock from supply when there are product recalls. The pharmacy team tries to work in an organised way and the delivery driver understands the potential risks of posting medicines. The pharmacy's team members prepare compliance packs safely. But they could do more to make sure that people who receive prescriptions for higher-risk medicines get all the information and advice they need to take their medicines safely.

Inspector's evidence

The pharmacy's opening hours were displayed at the entrance. There was a limited range of health information about self-care displayed in the retail area. There was no practice leaflet displayed which could mean that people don't know about all the services the pharmacy provides. The pharmacy delivered medicines to some people. There was an audit trail for this service to show that medicines had reached the right people. Medicines were generally not posted through letterboxes and this was only done if it had been risk-assessed first. In most cases, a note was left if no-one was available to accept the delivery and the medicines were taken back to the pharmacy.

The dispenser was observed referring to the prescription when choosing medicines and creating dispensing labels. Baskets were used to keep prescriptions for different people separate. Prescriptions that were not urgent were placed on a shelf above the dispensary workbench so they could be checked at quieter times.

The pharmacy supplied medicines in multi-compartment compliance packs to some people who lived in their own homes. The dispensers tried to prepare these packs on a separate workbench at the side of the dispensary. They had individual records for the people receiving these packs and added notes to the electronic patient record when there were changes or other interventions. The packs seen were labelled with the dose and a description of the medicines added. There was an audit trail on the packs to show who had dispensed and checked each pack. More than one dispenser knew how to prepare these packs so there was continuity of service for holidays. The packs were generally checked and sealed on the same day they were prepared; this was done at quieter times of the day to reduce the risks of distraction. The labels were attached to backing sheets, but the backing sheets weren't attached firmly to the packs. This could mean that important information about the contents of the packs gets mislaid. The dispenser explained how any mid-cycle changes were handled; packs were retrieved from people, the changes made, and then resupplied. Patient information leaflets were supplied every four weeks.

The pharmacy had the current safety literature about pregnancy prevention to provide to people when supplying valproate. The SI was aware of all the updated guidance about supplying this medicine safely but said the pharmacy didn't currently supply anyone in the at-risk group. The pharmacy highlighted prescriptions for some CDs so that members of staff could check they were still valid when handing the medicines out. But Schedule 4 CDs were not highlighted in the same way. The SI understood the types

of checks that he should make when supplying higher-risk medicines such as warfarin so that people were given advice about possible side-effects and to make sure that people were taking the right dose. He also had educational literature to provide to people. There were stickers available to highlight these prescriptions, but these were not always used.

The pharmacy got its medicines from several licensed suppliers. Medicines were generally stored in an organised manner on shelves in the dispensary. But storage space was limited, and some medicines were not clearly separated which could increase the chance of selection errors. Waste medicines were stored in designated bins. The pharmacy did not keep records of date-checks undertaken but said this was done regularly. Keeping a record of checks would make it easier for the pharmacy to be sure that all parts of the dispensary were checked. There was some evidence that medicines with short shelf-lives were highlighted and the dispenser said she tried to check dates of medicines during the dispensing process. Most liquid medicines had the date of opening added to the container when needed so dispensers could assess that the medicines were still safe to use. Two packs of a CD were found in the CD cabinet which were out of date and had not been marked to highlight this.

Medicines that required refrigerated storage were kept in one of two pharmacy fridges. Maximum and minimum fridge temperatures were monitored and recorded for one of these fridges but not for the other. There was enough storage capacity in the fridges and no evidence of ice build-up. The records viewed about one fridge showed its temperatures had remained within the required range and the thermometer showed that the temperature at the time of the inspection was within this range. The inbuilt thermometer on the second fridge indicated that the temperature had risen above the usual maximum of 8 degrees Celsius, but the team didn't know how to reset this or take the maximum and minimum temperature readings.

The pharmacy received alerts about medicine recalls and safety alerts via email and the SI was aware of the most recent notification. The SI explained how he responded to drug recalls by checking stocks and quarantining any affected medicines, if needed. He also sent a response, where required, using the facility on the alerts. However, the pharmacy didn't keep any other records about recalls. This made it harder for them to show that all relevant alerts had been acted upon appropriately. The pharmacy had the scanning equipment it needed to comply with the Falsified Medicines Directive. Staff had yet to be trained in its use and SOPs were still to be developed.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services safely. And these are maintained appropriately.

Inspector's evidence

The electronic patient medication record system was only accessible to pharmacy staff and computer screens could not be viewed by the public. The pharmacy had cordless phones, so staff could move to private areas to hold phone conversations out of earshot of the public. Staff had access to a range of reference sources including online resources, so the advice provided to people was based on up-to-date information. The equipment used for measuring liquids was of an appropriate standard and was clean. Some measures were used solely for measuring CDs to prevent cross-contamination. There were denaturing kits available to ensure medicines were destroyed safely. Fire safety equipment and alarms were subject to routine maintenance checks.

What do the summary findings for each principle mean?

Finding	Meaning
✔ Excellent practice	The pharmacy demonstrates innovation in the way it delivers pharmacy services which benefit the health needs of the local community, as well as performing well against the standards.
✔ Good practice	The pharmacy performs well against most of the standards and can demonstrate positive outcomes for patients from the way it delivers pharmacy services.
✔ Standards met	The pharmacy meets all the standards.
Standards not all met	The pharmacy has not met one or more standards.